TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
BAYLOR SURGICAL HOSPITAL

Respondent Name
CITY OF FORT WORTH

MFDR Tracking Number
M4-16-0106-01

Carrier's Austin Representative
Box Number 04

MFDR Date Received
September 14, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim listed above was not processed according to Texas fee guidelines for inpatient services.

TDI Commission Rule §134.404, section (f)(1) states that: The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

(A) 143 percent; unless

(B) Facility requests separate reimbursement for implants as specified in subsection (g), in which case shall be multiplied by 108 percent.

In regards to the claim listed above:

DRG 454 allowable equals $48,369.63 x 108% = $52,239.20

This claim involved implants. We are requesting separate payment of the cost of implants plus 10% as indicated in these guidelines.

Total cost of implants for this case was $60,312.12

Cost $60,312.12 x 10% = $62,312.12 (total allowable)

Expected implant reimbursement: $62,312.12."

Amount in Dispute: $27,499.04

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CorVel maintains inpatient services in dispute for DRG 454 were reimbursed in accordance with division adopted fee guidelines and payment policies in effect at the time services were rendered."

Response Submitted by: CORVEl

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 04, 2015 to March 10, 2015	Inpatient Hospital Service	$27,499.04	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the procedures for preauthorization, concurrent utilization review, and voluntary certification of healthcare.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' Compensation State Fee Schedule Adj
   - 193 – Original payment decision maintained
   - W3 – Appeal/Reconsideration
   - 150 – Payment adjusted/unsupported service level
   - 197 – Payment adjusted for absence of precert/preauth
   - IMP – Implant/DME allowance
   - 234 – This procedure is not paid separately

Issues

1. Did the requestor obtain preauthorization for the disputed services?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code P12 – "Workers' Compensation State Fee Schedule Adj", 193 – "Original payment decision maintained", W3 – "Appeal/Reconsideration", 150 – "Payment adjusted/unsupported service level", 197 – "Payment adjusted for absence of precert/preauth", IMP – "Implant/DME allowance" and 234 – "This procedure is not paid separately ."

   28 Texas Administrative Code §134.600(p) states "Non-emergency health care requiring preauthorization includes: (1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay."

   Review of the submitted documentation provided by the requestor finds no preauthorization for the disputed services of March 04, 2015 to March 10, 2015 for disputed inpatient hospital admission in accordance with 28 Texas Administrative Code §134.600(p).

   Therefore additional reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		10/16/15
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.